CMS Quality Measure Development Plan

Technical Expert Panel Meeting Summary

(MACRA Section 102)

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HSAG HEALTH SERVICES ADVISORY GROUP

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Technical Expert Panel Meeting Summary

I. INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) has contracted with Health Services Advisory Group, Inc. (HSAG) to develop and update the *CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)*[1] in accordance with section 102 of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA)[2] Under Contract #75FCMC18D0026, Task Order #75FCMC19F0001, HSAG ("the team") supports CMS in preparing annual reports on measure development for MIPS and Advanced APMs,[3] together known as the Quality Payment Program. The team also conducts environmental scans and gap analyses to expand upon the initial measure priorities and gaps identified in the Measure Development Plan (MDP).

As part of this contract, HSAG convenes a technical expert panel (TEP) of patients and family caregivers, clinicians and representatives of professional societies, consumer advocates, quality measurement experts, and health information technology specialists to provide multi-stakeholder input on project tasks and reports. The 2019–2021 TEP was selected through a call for nominations posted at CMS.gov/Medicare/Quality/Initiatives-Patient-Assessment-Instruments/MMS/Technical-Expert-Panels.

On October 19, 2020, the team convened a webinar meeting of this MDP TEP to obtain members' feedback on measure subtopics suitable for MIPS Value Pathways, a future state of MIPS that CMS envisions to include a foundation of low-burden measures focused on population health.[4] In preparation for the meeting, members used an online tool to individually rate measure subtopics derived from the draft *2020 MDP Population Health Environmental Scan and Gap Analysis Report*. The team used the TEP ratings to focus the discussions at the meeting, the objectives of which were to:

- Describe how the MDP Population Health Environmental Scan (e-scan) fits into the broader context of MACRA and the Quality Payment Program.
- Review the findings of the draft *2020 MDP Population Health Environmental Scan and Gap Analysis Report* and the TEP pre-assessment results.
- Prioritize population health measure subtopics according to the following criteria:
    - Clinician-level
    - Broadly applicable across clinicians
    - Aligned with CMS priorities for measure development

[1] Center for Clinical Standards and Quality, Centers for Medicare & Medicaid Services. *CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).* Baltimore, MD: US Department of Health and Human Services; 2016. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Final-MDP.pdf. Accessed October 26, 2020.
[2] Section 1848(s) of the Social Security Act (the Act).
[3] Centers for Medicare & Medicaid Services. Quality Payment Program measure development. Baltimore, MD: US Department of Health and Human Services https://www.cms.gov/Medicare/Quality-Payment-Program/Measure-Development/Measure-development.html. Accessed October 26, 2020.
[4] Centers for Medicare & Medicaid Services. MIPS Value Pathways (MVPs). Baltimore, MD: US Department of Health and Human Services; nd. https://qpp.cms.gov/mips/mips-value-pathways. Accessed October 26, 2020.

II. MEETING PROCEEDINGS

Welcome and Opening Remarks

Presenter: Kendra Hanley, MS, HSAG

Ms. Hanley, HSAG team lead for the CMS Measure Development Plan, welcomed the participants and CMS guests: Dr. Noni Bodkin, Contracting Officer's Representative, and Ms. Nidhi Singh Shah, MDP Technical Lead. Noting that the meeting audio would be recorded, she explained the teleconference technology and meeting procedures and reminded participants that meeting materials are proprietary to the project and cannot be shared externally without permission from CMS.

TEP Roll Call and Disclosures of Conflict of Interest

Presenters: Amy Mullins, MD, CPE, FAAFP, American Academy of Family Physicians; Michael Phelan, MD, JD, FACEP, RDMS, CQM, Cleveland Clinic Health Systems (*Co-Chairs*)

Invited Attendees/Attendance:

TEP		CMS (optional)	HSAG
☒ Anders, Scott	☒ Mullen, Cody	☒ Bodkin, Noni	☒ Campbell, Kyle
☒ Aran, Peter	☒ Mullins, Amy *(Co-Chair)*	☐ Durham, Maria	☒ Clark, Eric
☒ Bossley, Heidi	☒ Nguyen Howell, Amy	☒ Singh Shah, Nidhi	☒ Gilbertson, Eric
☒ Fields, Robert	☒ Nielsen, Matthew		☒ Gordon, Nancy
☒ Fishman, Eliot	☒ Phelan, Michael *(Co-Chair)*		☒ Hanley, Kendra
☒ Furniss, Jeremy	☒ Rising, Kristin		☒ Lockwood, Carolyn
☒ Huang, Mark	☒ Rogut, Lynn		☒ Pleasant, Michelle
☒ Kaufman, Joel	☒ Suter, Lisa Gale		
☒ Malinowski, Jana	☒ Tierney, Samantha		
☒ Mosnaim, Giselle	☒ Wisham, Lindsey		

Disclosures of Conflict of Interest

- Lindsey Wisham disclosed that her employer, Telligen, holds CMS contracts for developing and implementing clinical quality measures.
- Lisa Suter said that her employer, Yale Center for Outcomes Research and Evaluation, is a contractor to CMS working on MIPS measures—none related to population health.
- Samantha Tierney noted her prior role with the PCPI developing primarily clinician-level quality measures.

MACRA, the CMS Quality Measure Development Plan, and the Quality Payment Program

Presenter: Kendra Hanley, MS, HSAG

Ms. Hanley reviewed the background of MACRA and the MDP, which serves as a strategic framework for measure development for the Quality Payment Program, and mentioned the most recent MDP Annual Report, posted in June 2020. MDP project work includes e-scans and gap analyses. For this meeting, the team is seeking TEP input on findings from the latest e-scan report, which members received in draft form for their review.

The focus of the e-scan, population health, was intended to support the development of an anticipated reporting option for MIPS eligible clinicians. MIPS Value Pathways (MVPs), as envisioned in the CY 2020 Physician Fee Schedule proposed rule,[5(p. 40730)] will include a foundation of promoting interoperability and population health measures applicable to most, if not all, MIPS eligible clinicians.

In addition to considering the MVP framework in its deliberations, Ms. Hanley asked the TEP to remember that CMS prioritizes quality measures which:

- Focus on outcomes.
- Impose low to no burden on clinicians.
- Can be implemented as digital measures.
- Represent the patient/caregiver voice.
- Are aligned when possible.

A digital quality measure[6(p. 50280)] originates from sources of health information that are captured and can be transmitted electronically and via interoperable systems, she explained. Examples of electronic sources are EHR systems, health information exchanges, clinical registries, case management systems, electronic administrative claims systems, electronically submitted assessment data, and wearable devices.

Responding to a TEP request to "level-set on the way in which these measures will apply to specialties," Ms. Hanley explained that CMS is looking for population health measures to be broadly applicable across clinicians. MVPs are envisioned to include specialty-specific measures, but those are not the focus for this TEP meeting.

Another member asked what has happened with the TEP's 2018 and 2019 recommendations for development of clinician measure subtopics. Ms. Hanley said those subtopics are publicly posted as concepts for potential measure development. The team is tracking new measures for the Quality Payment Program and will include details in the 2021 Annual Report.

Analysis of Population Health Measure Subtopics

Presenter: Michelle Pleasant, PhD, MA, HSAG

Dr. Pleasant provided an overview of the team's eight-step approach to conducting the environmental scan. First, the team established the scope and terminology of the scan by defining population health as "health behaviors and outcomes of a broad group of individuals, including the distribution of such outcomes affected by the contextual factors within the group."

[5] Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations; Proposed Rule. *Fed Regist*. 2019; 84(157): 40482-41289.

[6] Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug Under a Prescription Drug Plan or an MA–PD Plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy Proposed Rule. *Fed Regist*. 2020; 85(159): 50074-50665.

Further, a population health measure was defined as "a broadly applicable indicator that reflects the quality of a group's overall health and well-being." Relevant topics include access to care, clinical outcomes, coordination of care and community services, health behaviors, preventive care and screening, and utilization of health services.

Next, Dr. Pleasant described how the team developed a conceptual framework and identified population health measure gaps by searching federal rules, national reports, and peer-reviewed and grey literature. The resulting gaps were then mapped to the conceptual framework under the topics previously mentioned. The team conducted a search for population health quality measures, using sources such as final rules and online quality measure databases for CMS and other federal quality reporting programs, as well as measure stewards and health care systems. The population health quality measures were evaluated and, if applicable, mapped to the conceptual framework. The mapping displayed 103 clinician-level population health measures and 35 gaps identified as measure subtopics for the TEP to prioritize for potential development.

Discussion of Population Health Measure Subtopics

Presenter: Kendra Hanley, MS, HSAG

Ms. Hanley reviewed the results of a pre-assessment in which 18 of 20 TEP members individually rated the 35 population health measure subtopics:

- 27 as appropriate for clinician-level measurement.
- 6 as not appropriate for clinician-level measurement.
- 2 split between appropriate and unsure whether appropriate.

Of the 27 subtopics designated as appropriate for clinician-level measurement, the TEP rated:

- 15 as broadly applicable.
- 12 as specialty-specific.

Finally, members each ranked their top 5 subtopics for future measure development for the anticipated MVP foundation. Aggregated rankings were calculated by reverse-scoring the assigned ranks and summing the reverse scores for each subtopic. The top rank was assigned to the highest sum; remaining ranks were assigned in descending order. Table 1 displays the TEP's top-ranked measure subtopics assessed as appropriate and broadly applicable to clinicians.

Table 1: Measure Subtopics Prioritized by TEP in Pre-Assessment

Rank	Topic	Subtopic
1	Access to Care	Telehealth
2	Coordination of Care and Community Services	Integration of mental health, substance use and physical health
3	Health Behaviors	Health literacy
4	Access to Care	Foreign language interpretive services
5 (tie)	Utilization of Health Services	Emergency department – inappropriate utilization
5 (tie)	Health Behaviors	Smoking
8	Clinical Outcomes	Well-being

*CMS requested TEP input on the 8th-ranked topic, well-being.

Appendix A, Table-A-1, contains detailed results of the TEP's pre-assessment ratings of all 35 population health measure subtopics.

General Comments From the TEP on Population Health Measure Subtopics

1. Access to Care: Telehealth
Main Takeaways: TEP members considered possible telehealth measures focused on access to care and quality of service. Multiple TEP members emphasized the ability of both the clinician and the patient to use telehealth technology—telephone as well as video. Limitations in use of administrative claims data were discussed, along with the possibility of creating a patient-reported outcome measure to evaluate whether telehealth addressed a patient's needs and concerns.

Discussion Notes
TEP Comment: It's great to have telehealth widespread as an option for patients because it expands the options for patients to get health care, so a critical issue. If we develop any measures, we need to take into consideration that it is not just the provider having the ability to do it; it is also the consumer having the ability to use the technology.
TEP Comment: I agree with the prior statement. This is one of those tools that can help with issues such as inappropriate [emergency department (ED)] use. For population health, we think of what is best for the population and what is best for the patient. If we do implement this as a digital measure, then we can look at this [measure] using codes for a percentage of overall visits. The percentage of patients that are eligible for this perhaps becomes the denominator. This is a low barrier for entry. We start forcing the system to address the issues just identified.
TEP Comment: I am taking a contrary view to this [subtopic] and a lot of the others being proposed as individual clinician measures. Certainly telehealth is very important, especially given the current pandemic. There have been efforts by CMS to encourage measure developers to add the telehealth codes where they are not already added to assess quality of care. That certainly speaks to low burden. I would be hard pressed to understand how this could be appropriate at the clinician level—maybe a higher level of measurement, like a health plan or health system.
TEP Comment: As a patient who is experienced with both telehealth visits and non-telehealth visits since the pandemic, it is important to offer the opportunity, so coming in the office is not a barrier, either. To think about a measure that would have the patient voice, it would be: Did I have the same quality of care? Did I perceive the same quality of care and attention in a telehealth appointment as I would [in] a regular in-person appointment? In personal experience, there has been great variance, from connectivity issues (e.g., internet, phone issues) to did I receive the same conversation and in-depth follow-up and concern as I would in an in-person visit? This may not reflect low burden as a patient-reported measure, but I feel that is more valuable from a patient perspective.
TEP Comment: I agree with the last speaker. We need to make sure we define telehealth properly—not just video, but also telephone. That broadens the measure a bit. That is one reason why this can be a clinician-/provider-specific measure.
TEP Comment: When I think of measures related to telehealth, I think of a broad span of measures. Certainly, there is the individual clinician use and leverage of the technology. Just as the last two speakers noted, something akin to an expansion of [Consumer Assessment of Healthcare Providers and Systems] measures [would] really get at the patient experience with telehealth and if it meets their needs. Another important measure could be something that gets at the [clinician-patient] relationship with appropriate decision-making for when to use telehealth visits,

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such as proportion of telehealth visits versus in-person versus adverse outcomes. There are many measures that could be low burden, such as access, technology, and utilization, at a health system or [accountable care organization (ACO)] level. It's hard to think about the concept of a telehealth measure at the clinician level when there are so many potentially embedded concepts with the appropriate and good use of telemedicine. I agree with telephone and video and nuances in measuring telehealth.
TEP Comment: I agree it is hard to measure at the clinician level. Thinking of telehealth as access to care, one important point to remember is it is not about comparing telehealth to in-person visits, but looking at differences such as same-day cancellation rates and no-shows for patients. This is just one aspect of access to and use of telehealth. Rates and reasons for using telehealth can vary for each clinician, but can be examined at every level. [The speaker offered a contact at Jefferson University who implemented a systemwide telehealth program six years ago.]
TEP Comment: I agree with all that has been said. Two additional thoughts: The first is concerning overuse, linking to an aspect of quality for telehealth interactions. Overuse has been a big concern for escalating costs. [Second,] whether telehealth visits help patients. Was the problem diagnosed properly? Was treatment suggested or ordered to address the problem? If those aren't happening, then overuse can be a real issue.
TEP Comment (via chat): Another factor to consider is that there are many patients who decline to use telehealth even when they have the capability to do so.
TEP Comment: The more important thing to evaluate with a set of measures is whether, from the patient perspective, the need has been met. Does it meet their expectation and [is] their problem solved? But it puts additional pressure on outcomes measures in the same set. We want to have some measure of patient experience that the visit met their need, and then that we controlled blood pressure and diabetes. [Emphasis] should be on the clinical outcome measures that come along with it rather than telehealth visits as the end outcome.
TEP Comment: Important for this measure is consideration for urban versus rural. Rural facilities have used telehealth longer and for more specialty and primary visits. As we think about and develop the measure, consider the rural perspective and weight that appropriately, [whether] at the clinician level or more system, ACO payment model level.
TEP Comment: [The speaker questioned] whether this applies to certain providers or a raw telehealth option. Analogy is to the HITECH [Health Information Technology for Economic and Clinical Health Act] incentives to [electronic health record (EHR)] adoption. First, this was a technology that should be incorporated into practice. Ultimately, there were elements to EHR that were more than just raw adoption, but initially there was a phase that was just adoption. As we try to get telemedicine to be a more permanent part of practice beyond the pandemic, it is appropriate to have a raw measure to assess if clinicians are adopting this—very similar to early EHR adoption.
TEP Comment (email): Re access to care – telehealth: A recent study in New York during the pandemic found that Black and Hispanic patients have lower odds of using telehealth versus either the ER or an office visit than either Whites or Asians. That paper noted that disparities in digital access, digital literacy, and telehealth awareness, as well as issues of cost and coverage, and mistrust of digital appointments where physical examinations, labs and vitals cannot be taken, are all potential barriers to telehealth. https://academic.oup.com/jamia/advance-article/doi/10.1093/jamia/ocaa216/5899728

2. Coordination of Care and Community Services: Integration of mental health, substance use, and physical health
Main Takeaways: Although TEP members voiced support for the measure subtopic, several described challenges in the current health care environment to creating a quality measure that would hold clinicians accountable. A TEP member suggested starting by creating a baseline measure assessing a clinician's referrals for mental health and or substance use issues; other members agreed with an incremental approach to measurement. Limitations with CMS's goal for no-burden measures were noted, and a TEP member observed that the subtopic seemed to indicate a process rather than an outcome measure.

Discussion Notes
TEP Comment: I love the concept but find it extraordinarily hard to measure and [determine] how to hold clinicians accountable. In rehabilitation, with certain populations there is high incidence of depression, PTSD, some substance use issues, and we identify these as problems and gaps but have no idea of who we send them to, what insurance covers, and what provider can take them. How [do you] hold a clinician accountable when we recommend it and then there is no resource to get it done? Or the insurers won't pay for it? Or no providers are willing to take that insurance? How do you measure to get a better outcome if the infrastructure isn't there?
TEP Comment: Think of this subtopic as an ideal state—a nirvana—fully integrated for the patient to know that when they see a provider, their physical and mental health and substance issues will be addressed. If we start with the first step, can a provider be accountable for identifying the need is there, helping the patient put the first foot in front of the other? Patients left to their own devices may not know where to get help. A provider may be equipped to help with a referral and where to go. If we don't address this by at least taking one step forward, then patients may not know where to go.
TEP Co-Chair: In summary, the effort to make a referral could be the first step.
TEP Comment: When we talk of physical health, mental health, and substance use, which one is it? We need to know which metric is being assessed and [be] more specific. If I address one, does it count, and am I doing the patient a service? To put together [programs] to get this up and running and sustainable in the longer run [is] certainly not a low burden. … Overall, this is going to be difficult, needs to be more specific, and feels more like a process measure.
TEP Comment: I agree that this would be hard to have an accountable measure at the clinician level that is actionable [and achieved with claims data]. But the referral use could be a way to create the measure, possibly with EHR, although I don't know how common EHR use is across the country. Maybe look at a physical visit and a mental health visit within the year if you want to think of claims data. I don't know if the provider would want to be accountable for that.
TEP Comment: I agree with a lot of the prior comments. It's very difficult to measure these outcomes at the clinician level, and if you layer on top of that using administrative claims, we won't be able to get to what we really want to know, which is the quality of services and not just whether they occurred or if there was a referral. Something for CMS to consider is how hard it will be to get to something that is truly useful, that is actionable. Claims data [are] retrospective, provided a year-plus after the fact, and not useful to clinicians. I'm not sure how we get around this issue.

Discussion Notes
Team Comment: In the proposed rule, CMS was looking for broadly applicable measures, implemented with claims. But CMS also is open to hearing about measures that are implemented as low burden. If there are other thoughts or ideas for how to address something actionable as a low burden, that is something CMS wants to hear.
TEP Comment: This is an important and critical area where our system has failed many people. It could be a good baseline measure versus an accountability measure, as many providers may not know how they perform on this measure right now. I agree this is hard and tricky, but this is such an important area for us to at least start to measure in a systematic way to provide feedback to clinicians so we can get better at measuring it.

3. Health Behaviors: Health Literacy

Main Takeaways: TEP members stressed the importance of health literacy, calling it foundational to treating patients, although it may be challenging as a broadly applicable measure. Ensuring health literacy can empower patients to be active participants in their care, they observed. A TEP member suggested assessing whether a provider is using the teach-back method with patients and translating action plans to picture-based guidance to enhance understanding.

Discussion Notes
TEP Comment: I rank this one very high from a patient perspective. If we are truly thinking about patients as partners in their care, providers are only part of the equation. Patients have to be compliant with medication and take the advice of their provider. If they don't understand what's being asked or access the information to improve their own health, then we're not going to get very far in other outcome measures. This is a foundational concept that patients are health literate. Even though I'm involved in health care policy, there are still topics and discussions that I need to ask for clarification because of medical terminology. We have to check with patients, so they understand what is being asked of them, how to be compliant, how to take action and be that partner in their own health care.
TEP Comment: This is one of the most important concepts; everything else follows from it. If our patients don't understand what clinicians are saying or handing them to read, then we can't treat them. This concept is also important for another whole host of measures to understand a patient's comfort [with] what we are sharing, such as the medical terminology, medication dosing, and all the other aspects of health literacy. I don't know if this is easy to establish [as] a low burden measure, but it's worth the investment.
TEP Co-Chair: This reminds me of the telehealth discussion from the patient perspective, asking, Did the visit meet your need? Health literacy [measures] ask patients, Did you understand the visit?
TEP Comment: This is extremely important. There are some things here we can measure: Did the clinician use teach-back methodology for the after-visit summary and the care plan? In terms of health literacy, we can measure whether the materials for asthma, diabetes, or hypertension are understood and can be used by the patient to manage their care at home. At our institution, we use the completion of the asthma control test and a written asthma action plan as quality measures. We are moving toward using picture-based asthma action plans and making sure the language is appropriate.

Discussion Notes
TEP Comment: I agree with prior comments that this is the top topic of the day. I struggle with how to do this from a broad population perspective. An initial step would be to look at a recent [National Quality Forum (NQF)]-endorsed patient-reported outcome measure—not low-burden—assessing effectiveness of counseling on reproductive health and planning for women post-partum. There are ways to look at this to make it meaningful and actionable for the patient and provider.
TEP Comment: There is an opportunity to utilize an initiative that will be in place in the next six months: the implementation of the 21st Century Cures Act. This will require clinicians to open up electronic medical records to patients, and a requirement to communicate is implicit there. Parallel to what we are doing when we make these new measures, we can leverage these notes to make [health literacy] better.
TEP Co-Chair: This will be a two-way process with electronic health records, where patients can read a plan on their app and say if they did or didn't understand. As this process goes to more open notes, maybe at some point, this could be measurable.

4. Access to Care: Foreign language interpretive services

Main Takeaways: TEP members agreed on foreign language interpretive services as an important concept for potential measure development and noted a direct link between this subtopic and health literacy. Examples of how technology is enabling better access to interpretive services were shared. One TEP member raised a question about how to document appropriate translation, including access to a clinician who speaks the patient's primary language, in the electronic health record.

Discussion Notes
TEP Comment: This is critically important. I remember years ago when we would have to call a person to come and interpret, and sometimes they would have to wait for the clinician to be available. But now we can use what we call a rover—it's an iPad on wheels—and an interpreter of whatever language you need comes up. We can access the interpreters just in time at the point of care. The patients generally very much appreciate it because they see and hear the interpreter [on the screen]. I think it reduces cost, and it tremendously improves the ability to communicate with the patient and make sure that they do understand. This is something that can be digitally measured, is low-burden, and can be an outcome measure.
TEP Comment: [Providing interpretive services] is a required service in Medicaid, but it is still not necessarily widely available in every state. Oregon has been working for years to implement a measure of interpretation services as a health equity measure in its Medicaid managed care program, working through the accuracy [issues] and burden around this measure. This is a great measure [subtopic], and I wanted to recommend Oregon's experience be part of the measure development process. [The TEP member later emailed a link to the Oregon Health Authority website with information about the measure and the program implementing it.] *Measure description: The proportion of visits with spoken and sign language interpreter needs that were provided with OHA qualified or certified interpreter services* *Denominator: Total counts of visits from members who need interpreter services* *Numerator: Total counts of visits when spoken and sign language interpreter services were provided by: certified interpreters; qualified interpreters; interpreters NOT certified or*

Discussion Notes
qualified; bilingual staff. The denominator is derived from the Coordinated Care Organization (i.e., plan) reporting as part of a section of their Medicaid information system.
TEP Comment: The question that I have is the challenge of determining if interpretation was appropriate: [If a clinician could converse in the patient's primary language, and therefore, interpretive services were not needed], how to record that within the [electronic medical record (EMR)] where interpretive services are noted. We don't load patients' primary languages in the system and then do an internal audit.
TEP Co-Chair: It may be something in the physician profile that comes up. That's a challenge, but I don't think it would be prohibitive to trying to develop that kind of widespread metric. But it's a good point.
TEP Comment: This is a very important [subtopic]. I work in a large hospital, so we have all the resources available. For small practices, it's a burden. Along with the measure, there has to be a way to pay for it. There are small practices in the community that don't have the access to all these services, so they refer to our larger hospital system with a question—not something they couldn't have answered; it's just that they didn't want to pay for interpretive services. If we recommend this, we also have to recommend that it not be a burden to smaller practices.
TEP Comment: [The speaker agreed and mentioned testing a translation app on her phone.] Just like with telehealth, there are a lot of new technology options that are very, very accurate.
TEP Comment: This is a very foundational tech concept, along with health literacy. We can't expect that patients understand what's expected of them and be able to carry out the recommendations if we don't feel that we're clearly communicating, so obviously language can be a barrier. I do think this has the potential of being a low-burden measure—not getting to the outcome part of it, but introductory measures that at least start us down the right path.

5 (tie). Utilization of Health Services: Emergency department – Inappropriate utilization
Main Takeaways: TEP members cautioned against labeling an ED visit "inappropriate" or "avoidable" based on information known only after treatment. They raised concerns about unintended consequences, and one member observed that the ED is "the one place of all health care that is guaranteed at some level to anyone that walks through the door." A physician member said an increase in immediate care centers in her health system had lowered the census in the ED, while two others countered that stand-alone urgent care in their practice areas had not significantly changed ED utilization.

Discussion Notes
TEP Co-Chair: This is a very important topic, an area that definitely needs measurement. I am unsure if it can be an outcome. The difficulty bringing this down to clinician- versus health system-level measurement is quite challenging.
TEP Comment: I think this is a critically important measure [subtopic]. Over the past five years at our institution, we went from two immediate care centers to 19. In this way, patients can get care immediately in a convenient way. There are a lot of services that can be done, like blood work and x-rays. The census in the emergency department is down because rather than a patient going to an ED when all other offices are closed, they go to an immediate care center, which is a low-cost alternative staffed with midlevel [clinicians]. So if there was a way to measure the decrease

Discussion Notes
in ED use and the increase in immediate care use, with patient satisfaction and decreased cost with favorable outcomes, this could be a win-win situation for patients and the health care system. **TEP Comment:** As an emergency system doc and a researcher around patient needs and patient-centered design, I struggle with any sort of terminology that gets at "inappropriate" or "avoidable" utilization because the lens we look at, whether it's the system lens, the clinician lens, the patient lens, and at what time we look at it—before the visit, in the middle of the visit, or after the visit—changes everything about our assessment. I am hard pressed to think that we could come up with a measure that would not be significantly harmful to one or more groups. … Opening up [an urgent care] center does not necessarily change ED volume. I think it's a really complicated question, and I have a lot of hesitation around this measure. I saw a patient some years ago … all the social service system had fallen through for her. She lost her food stamps; she lost her housing. She had her [menstrual] period; she truly didn't have a dime to get herself pads, and she had bled through all of her clothes. That's a totally inappropriate ED use by the system's assessment and by the payer's, but for that patient, her life was an emergency at that point, and actually that visit was what she needed. I see those scenarios in so many different ways that I think this measure has potential to do significant harm. This is a very personal topic for me and many others who look at ED system design issues. **TEP Co-Chair:** [Agreeing] It was inappropriate for an emergency physician to come in with that complaint, but maybe not for this patient. That's an issue that comes up all the time, a mom who's concerned about her child at 10 o'clock at night with no other resources to go to. I'll be glad to educate her and talk to her about her child's earache and make sure she gets the appropriate follow-up. **TEP Comment:** Most of us in value-based care have had experiences with measures like this for a long time. The point of quality measures is to evaluate either a physician, a practice, a plan, an institution. Because of the need to make a clinical decision at the point of admission from ER, inpatient utilization measures generally do a better job at reflecting the management of chronic conditions. So I feel a lot better about inpatient admissions per thousand, for example, as a measure, as opposed to inappropriate ER measures. It is a product of so many factors, including what is most convenient, what is accessible, the perceived need to pay because we've designated ER as the one place of all health care that is guaranteed at some level to anyone walking in the door. In our market in New York, urgent care has not really changed our ER utilization much at all; it's just provided another access point, frankly, for mostly fragmented care. I have similar concerns about these measures; I think they're overutilized as it is. **TEP Co-Chair:** Reports have come out about inappropriate ED utilization. That's after the fact, utilizing those codes, to say those are really inappropriate ED utilization. When someone's got chest pains or severe ear pain, they don't know what it could be, so they come to the ED. … Saying all those could have been done somewhere else is kind of a heavy burden. **TEP Comment:** I agree with the discussion, and it's important not to blame the patient for the inappropriate utilization because it's appropriate to that patient, but it may be inappropriate to the system. When their primary care physician isn't available or accessible by phone to give advice, the patient does what is appropriate to them. To me, the better measure would be, from the clinician standpoint, what percentage of patients go to the emergency room for diagnosis that could have been seen in the office?

Discussion Notes
TEP Comment: I agree that you can't ask patients to diagnose themselves and figure out if it's an appropriate or inappropriate ER visit. Access is a good point, but you have to be careful with that. At some point, one of your patients may end up in the ER if you're not open at 2 o'clock in the morning and they don't like the advice they got on the phone.
TEP Comment: Regarding primary care access, I have done a lot of qualitative work with patients around issues such as alternatives to going to the ED. What I hear from most patients is when they choose to come to the emergency department, they're choosing that for a reason, and it's not just that they couldn't get to their primary. In fact, they don't want to go to their primary when they are scared about symptoms and they feel that the ability to get symptom support and testing isn't at the primary care. Making sure primary care can see them is not the patient-centered answer.
TEP Comment (email): While seemingly designed to incentivize health systems to develop sufficient services to address patients' needs in the non-ED setting, in actuality this measure ends up being highly patient-blaming and fails to account for the perspective and needs of each individual patient. It is, in essence, a backwards step in developing measures to ensure patient-centered care delivery. The time point at which this measure is applied also highly impacts the assessment of "appropriateness" – the most common (and feasible) approach is to apply based on discharge diagnosis, and yet this diagnosis has been determined often after significant testing and treatment. While there has been discussion about using chief complaint as a much better assessment point (see recent NQF report "Advancing Chief Complaint-Based Quality Measurement Final Report"), there are no standardized approaches to being able to do so as of now. Finally, if applied as a provider-level incentive, it is concerning that this metric could end up disincentivizing providers from taking on at-risk patients (e.g. those with mental health disease, high needs related to social determinants of health).

5 (tie). Health Behaviors: Smoking
Main Takeaways: The TEP discussed smoking as impactful to patients' health and acknowledged that outcomes such as smoking cessation would be worth measuring. A physician member expressed concern about measuring an outcome such as percentage of patients who smoke at the individual clinician level. Another member suggested a system- or community-level rather than clinician-level measure.

Discussion Notes
TEP Co-Chair: This is a really important topic, getting the idea of talking to your patients about quitting smoking and coaching or counseling them, being that there are identifiable codes for brief smoking cessation counseling and maybe even longer, and. maybe the ability to follow outcomes on that: Did a patient change their smoking? Smoking is something that is so impactful to the health of our patients that it would be great to measure outcomes if possible.
TEP Comment: As a primary care clinician, I could counsel them all day long, but if the outcome is making your patient stop smoking … it's their decision. And holding a clinician accountable for having the patient choose to stop smoking is not a fair clinician-level measurement.
TEP Co-Chair: Maybe this is one of those [subtopics] better served as a system- or community-level rather than clinician-level measure.

Discussion Notes
TEP Comment: [Referring to experience in a medical practice measuring response to counseling about smoking] It could be that there's a 15% reduction in smoking in a clinician's practice. You'd say that's terrible, but against peers, that was great, because everyone else was 10%. If measure results are compared peer-to-peer, no one clinician will be judged on the one patient that is noncompliant or has multiple [risk] factors.

8. Clinical Outcomes: Well-being

Main Takeaways: Physician TEP members expressed strong reservations about well-being as the basis for a pay-for-performance measure. Some stated that holding a clinician responsible for a patient's outlook on life would be unfair, although one physician opposed to the subtopic noted that measurement would compare clinicians peer-to-peer rather than in absolute terms. Well-being was described as a subjective and fluid concept, of which health is but one component. One member suggested, rather than trying to elevate well-being across a population through provider incentives, that CMS employ a confidentially reported metric which would heighten awareness of patients who need additional resources.

Discussion Notes
TEP Comment: Anyone who thinks that this is appropriate for clinician-level measurement has never been a primary care clinician [acknowledging being "completely biased" in that role]. It's completely inappropriate for me to be held accountable for someone's perception of their well-being.
TEP Comment: The difficulty here is well-being is such a subjective concept. Even from a patient's perspective, it changes daily. My mind goes back to the integration of the mental and the physical and substance abuse type care for a patient. If we can mobilize patients toward those services they need, then in effect you are contributing to the well-being. But I agree there are going to be patients that you cannot change their outlook on life, and holding a physician accountable does not seem fair. This topic points to where we actually need to take action, which is how do we connect patients who need additional mental health services and how could we affect their well-being or the perception of their well-being?
TEP Comment: I do think it's an important concept. If it were to be implemented at any level, it would require robust risk adjustment. Self-defined well-being is incredibly fluid, both within and across individuals, and influenced by many things that aren't necessarily specific to medical care. Appropriate risk adjustment will be incredibly difficult. What might be more appropriate or more useful is rather to think about this as a confidentially reported metric, an opportunity to reflect on the patients that need additional resources as opposed to trying to elevate well-being across a population through provider incentives. Maybe it's a stratified measure, stratified by important social risk factors, so that we are aware of disparities within our practices. That kind of thing has utility, but not as a pay-for-performance metric.
TEP Comment: I do not like this measure [subtopic], so I wouldn't go forward with it. I think we have to be careful with accepting clinician responsibility and remember that it's not an absolute; no one's going to be judged on the one patient that is noncompliant or has multiple [risk] factors, but we would measure against other clinicians.

Discussion Notes
TEP Comment (quip): If it becomes a measure, I'm going to become a physician in Aspen, Colorado, rather than [urban practice location].
TEP Comment (email): Thank you for inclusion in these important discussions. My concern around the well-being metric is one of definition and meaning to the individual, organization or society. Well-being in general is described as the state of being happy, healthy, or successful. As a physician or organization, I'm/we're not responsible for a patient's success (again, successful in what?) or even happiness. Obviously we want our patients to be successful and happy, but it's not our mandate. Mental health/general health is incredibly important, but actually quite nuanced. Happiness or success has many, many more psychological and socioeconomic drivers (think social determinants of health) that have a greater impact on an individual's well-being (general sense of the word) than what we do as providers for our patients and communities. Health is one component.
TEP Comment (email): Re[garding] well-being, there are[patient-reported outcome measures that are being used to measure health stressors – in case of interest, here is a link to an example. An instrument of this type could be used to track trends in stress over time – perhaps a more meaningful approach to engaging clinicians in attending to stressors that affect patient well-being (individual or a panel, but not for quality measurement and not so much for payment purposes). https://uhfnyc.org/media/filer_public/11/88/1188e94b-dc86-4b60-80ce-840afb463f6e/uhf_patientreportedoutcomes_fieldreport_montefiore_final_rev3b.pdf

Concluding Remarks and Next Steps

Presenter: Kendra Hanley, MS, HSAG

Ms. Hanley asked members to complete a meeting evaluation and a post-meeting assessment reranking the seven measure subtopics discussed. She encouraged members to email additional comments to the team via MACRA-MDP@hsag.com for inclusion in this summary, which will be provided to the TEP for review and comment. Reviewing next steps, she mentioned a TEP meeting focused on the Quality Measure Index, scheduled for January, and the posting of the population health e-scan on a timeline to be determined. She closed the meeting with thanks to the members for their participation and to CMS for its support of the project.

III. TEP RECOMMENDATIONS

Results of the TEP Discussion and Post-Meeting Assessment

Table 2 details the results after 19 of 20 TEP members completed a post-meeting assessment to re-rank the population health measure subtopics they had discussed.

Table 2: Population Health Priorities – Subtopic Results of TEP Post-Meeting Assessment:

Rank	Topic	Subtopic
1	**Access to Care**	Telehealth
2	**Health Behaviors**	Health literacy
3	**Access to Care**	Foreign language interpretive services
4	**Coordination of Care and Community Services**	Integration of mental health, substance use and physical health
5	**Health Behaviors**	Smoking
6	**Utilization of Health Services**	Emergency department – inappropriate utilization
7	**Clinical Outcomes**	Well-being

The two assessments provided a pre- and post-meeting comparison of priorities. In the post-meeting assessment, TEP members ranked health literacy and foreign language interpretive services higher than before, moving them from third and fourth place to second and third, respectively. Emergency department – inappropriate utilization, previously tied with smoking for fifth place, dropped to sixth. Telehealth and well-being remained the top- and lowest-ranked measure subtopics, respectively.

After completing the post-assessment, one TEP member commented, "My takeaway from the meeting is that PROMs [patient-reported outcome measures] will play a key role in assessing well-being, health literacy, access and quality of telehealth too."

Another TEP member provided a list of references to peer-reviewed journal articles and grey literature sources related to emergency department utilization:

- Ambulatory Care: Emergency Department Visits
- Chartbook on Care Coordination: Preventable Emergency Department Visits
- Emergency Department Utilization as a Measure of Physician Performance
- Factors Associated with Inappropriate Use of Emergency Departments: Findings from a Cross-Sectional National Study in France
- Quality Measurement in The Emergency Department: Past and Future
- Reducing Preventable Emergency Room (ER) Utilization
- A Systematic Review of Interventions on Patients Social and Economic Needs
- Understanding Why Patients of Low Socioeconomic Status Prefer Hospitals Over Ambulatory Care

At the request of CMS MIPS program leads who were interested in TEP feedback on these population health subtopics gaps, this TEP Meeting Summary will be provided for input as CMS considers the anticipated population health foundation for MVPs. TEP results also will be included in the next MDP Annual Report in spring 2021.

APPENDIX A – TEP PRE-ASSESSMENT

Table A-1: Population Health Subtopics – TEP Rating Results

Topic	Measure Subtopic	Yes, Appropriate % (n)	Not Appropriate % (n)	Unsure if Appropriate % (n)	Missing % (n)
Access to Care	Availability – rural	33% (6)	50% (9)	11% (2)	6% (1)
	Foreign language interpretive services	67% (12)	22% (4)	6% (1)	6% (1)
	Health insurance coverage – child	22% (4)	**50% (9)**	28% (5)	0% (0)
	Nutritional support for older adults	**61% (11)**	28% (5)	6% (1)	6% (1)
	Telehealth	**78% (14)**	17% (3)	0% (0)	6% (1)
Clinical Outcomes	Interpregnancy interval	50% (9)	11% (2)	33% (6)	6% (1)
	Morbidity – opioid-related	50% (9)	28% (5)	22% (4)	0% (0)
	Mortality – cancer	56% (10)	28% (5)	17% (3)	0% (0)
	Mortality – maternal	56% (10)	22% (4)	22% (4)	0% (0)
	Mortality – opioid-related	44% (8)	28% (5)	28% (5)	0% (0)
	Mortality – premature	39% (7)	22% (4)	39% (7)	0% (0)
	Poor birth outcomes	56% (10)	28% (5)	17% (3)	0% (0)
	Postpartum complications	89% (16)	0% (0)	11% (2)	0% (0)
	Well-being	50% (9)	28% (5)	22% (4)	0% (0)
Coordination of Care and Community Services	Breastfeeding support	67% (12)	22% (4)	11% (2)	0% (0)
	Employment	17% (3)	67% 12)	17% (3)	0% (0)
	Housing	28% (5)	61% (11)	11% (2)	0% (0)
	Integration of mental health, substance use, and physical health	61% (11)	22% (4)	17% (3)	0% (0)
	Social support for older adults	44% (8)	50% (9)	6% (1)	0% (0)
	Community collaboration	33% (6)	6% (1)	22% (4)	0% (0)
	Timely transitions in care – substance use disorder	83% (15)	44% (8)	0% (0)	0% (0)
	Transitions in care – rural	67% (12)	22% (4)	11% (2)	0% (0)
	Identification of community supports	50% (9)	17% (3)	22% (4)	0% (0)
	Support for opioid use disorder	67% (12)	0% (0)	0% (0)	0% (0)
Health Behaviors	Accident prevention – head injury	39% (7)	28% (5)	28% (5)	6% (1)
	Accident prevention – seat belt	39% (7)	28% (5)	28% (5)	6% (1)
	Distracted driving	33% (6)	28% (5)	33% (6)	6% (1)
	Health literacy	56% (10)	17% (3)	22% (4)	6% (1)
	Safe medication disposal	56% (10)	22% (4)	17% (3)	6% (1)
	Smoking	94% (17)	6% (1)	0% (0)	0% (0)
Preventive Care and Screening	Abuse and neglect	83% (15)	11% (2)	6% (1)	0% (0)
	Cancer screening – prostate	90% (16)	0% (0)	6% (1)	6% (1)
	Cancer screening – thoracic	90% (16)	0% (0)	6% (1)	6% (1)
	Caregiver risk assessment	90% (16)	0% (0)	6% (1)	6% (1)
Utilization of Health Services	Emergency department – inappropriate utilization	61% (11)	28% (5)	11% (2)	0% (0)

Qualitative Feedback From the TEP Pre-Assessment
TEP Comment: Some of my answers were based [on] potentially lower denominators for some of the measures.
TEP Comment: The development of population health measures will not be the hard part. The complication comes in the physicians having access to the appropriate and complete information needed for accurate measurement.
TEP Comment: These measures may be very difficult to assign to individual providers but could be voiced in aggregate or group practice setting, health system, and then be attributed. Many of these measures rely on patients being motivated and reliable.
TEP Comment: Telehealth is a TOP priority.
TEP Comment: Many of these measures above should apply to only specific groups, not all clinicians. Also, many of the coordination of care and community services should probably not be assigned to [eligible clinicians (ECs)], but to health care organizations instead. ECs barely have enough time to deliver care, and some of this should be offloaded.
TEP Comment: Linkages between health care providers and community-based social services [are] very important, and so is screening for identifying caregiver needs. I prioritized telehealth because of explosive growth, maternal mortality because of unacceptable disparities, ED because of high system costs, but feel strongly about care coordination.
TEP Comment: When developing population health measures, please give consideration to the ability to provide public reporting on these measures. Especially when looking at population health measures, that area applicable across a wide variety of clinicians, this information is extremely valuable to consumers of health care, including patients and families.
TEP Comment: Yes, I have a few comments on the draft [e-scan] report: (1) I see the one measure recommended for adoption has not been tested at the clinician level, so would say that would be one for adaptation instead. (2) I would say that perhaps we need to clarify what adaptation means—all too often, measures are adapted at the clinician level without any input from clinicians and without testing at that level. I would strongly recommend that we add that somewhere in this report. (3) I thought some of the topic areas were not representative of population health and too narrowly focused. I understand that you did extensive research to come up with your definitions. However, I would say that the way CMS described population health measures in the initial presentation of the MVPs, in that it "focuses on public health priorities and/or cross-cutting population health issues," resonates with me a little more. (4) Did you consider the IOM report, *Vital Signs: Core Metrics for Health and Health Care Progress*? In reviewing that report a few years ago, I found that to be pretty representative of population health measures, although many of them may not [be] relevant or appropriate for clinician-level accountability. Thanks for allowing me to share my input.
TEP Comment: Clarification around administrative claims measures: Based on my knowledge of current claims data, especially in the Medicare Part B setting, many of these concepts would be difficult to measure (outside of adding yes/no HCPCS codes).
TEP Comment: I rated some of the items as unsure about the classification since it was so general a topic, it was difficult to say yes or no. Depending on the intent of the measure, I might also change my classification. Bottom line, these measures should be actionable at the point of care, generated from electronic data sources to the greatest extent possible, and provide timely feedback. Questions around attribution and whether the measure yields reliable and valid results at the level of measurement must be carefully considered.

Qualitative Feedback From the TEP Pre-Assessment
TEP Comment: I am very concerned that the MVP framework intent of narrowing measure concepts to those oriented around population health will end up leaving many clinicians without meaningful measures of care in their specialty. I appreciate the desire to develop population health measure concepts, but it seems that most of these are more appropriately attributed at the organization/ plan level rather than individual clinician level.
TEP Comment: My understanding is very few OB/gyns (and likely midwives too) are paid through MIPS/QPP, so unclear whether/why maternal/fetal health measures should be a priority for MVPs.
TEP Comment: [Member proposed to add] consideration for assessment of "adverse childhood events" (ACE) for children and assessment of ACEs for adults with chronic health conditions and behavioral health conditions, including pain medicine addiction and alcohol addiction.
TEP Comment: Vaccinations, diet, exercise. I look forward to more discussion and background at the meeting. There are a number of maternal items that would not seem to be a Medicare priority. Items listed seem not applicable to many (most) specialties. Also, population health measures do not seem to be low-burden reporting if accuracy is expected.